EXHIBIT B

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient Date of Birth Social Security Number

This will authorize you to furnish copies of the following records and/or information **from the time period of twelve (12) years prior to the date on which the authorization is signed**:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

****Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501**.

1. To my medical provider: **This authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial**.
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. A copy of this authorization may be used in place of an original.
6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040**.**

Date:_____ _____
Patient/Representative Signature *[Print name if not Patient]*

Date:_____ _____
Witness Signature

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LARGER FONT VERSIONS OF THIS AUTHORIZATION AVAILABLE ON REQUEST